COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF
A HEARING UNDER *THE HEALTH PROFESSIONS ACT,*

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF BHAVNEET VERMA

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF BHAVNEET VERMA, LPN #45914, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted at the offices of the College of Licensed Practical Nurses of Alberta ("CPLNA") in Edmonton, Alberta on July 23, 2019 with the following individuals present:

Hearing Tribunal:
Nancy Brook, Public Member, Chairperson
Angelica de Vera, Licensed Practical Nurse ("LPN")
Christine Buck, LPN

Staff:
Tessa Gregson, Legal Counsel for the Complaints Director/Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Bhavneet Verma, LPN ("Mr. Verma" or "Investigated Member")
Mark Wells, Legal Counsel for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

There were no objections to the members of the Hearing Tribunal hearing the matter, and no Hearing Tribunal member identified a conflict. There were no objections to the jurisdiction of the Hearing Tribunal.

The Hearing was conducted by way of an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Joint Submission on Penalty.

(3) Background

Mr. Verma was an LPN within the meaning of the Act at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Mr. Verma was initially licensed as an LPN in Alberta on May 10, 2018.

On February 26, 2019, the CLPNA received a complaint from Luilynne Yusi-Salazar, RN, Clinical Practice Lead (the "Complainant") at Excel Society-Balwin Villa (the "Facility") in Edmonton,

Alberta (the “Complaint”). The Complaint was sent pursuant to s. 57 of the *Health Professions Act* (the “Act”) notifying that Mr. Verma, LPN was on administrative leave pending completion of an investigation of an abuse allegation against Mr. Verma.

On March 1, 2019, Ms. Sandy Davis, Complaints Director for the CLPNA (the "Complaints Director"), requested that Jeanne Weis, Executive Director for the CLPNA, impose an interim suspension of Mr. Verma’s practice permit pending the outcome of disciplinary proceedings pursuant to s. 65(1)(b) of the Act due to the serious nature of the allegations against Mr. Verma.

In accordance with s. 55(2)(d) of the Act, the Complaints Director appointed Kerry Palyga, Investigator for the CLPNA (the “Investigator”), to conduct an investigation into the Complaint. The Complaints Director further delegated her authority and powers under Part 4 of the Act to Susan Blatz, Complaints Consultant for the CLPNA (the “Complaints Consultant”), pursuant to s. 20 of the Act.

Mr. Verma received notice of the Complaint, investigation, appointment of the Investigator and the Complaints Director’s request for an interim suspension by letter dated March 1, 2019.

By letter dated March 7, 2019, Ms. Weis granted the request for an interim suspension effective the date of the letter.

On April 16, 2019, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Consultant determined that the matters should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Mr. Verma received notice that the Complaint was referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated May 27, 2019.

Since the referral to hearing, the Statement of Allegations was revised (“Revised Statement of Allegations”). A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Mr. Verma under cover of letter dated June 24, 2019. Mr. Verma waived the 30 day notice required under s. 77 of the Act.

(4) Allegations

The allegations in the Revised Statement of Allegations (the “Allegations”) are:

“It is alleged that Bhavneet Verma, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about February 3 to 4, 2019, failed to appropriately respond to client MG’s fall by doing one or more of the following:

a) Failed to adequately assess and/or document an assessment of client MG after a fall as required; and

b) Failed to complete post fall protocol monitoring and/or document on the Post-Fall Clinical Pathway as required.

2. On or about February 3 to 4, 2019, failed to adequately assess and/or document an assessment of MG after MG was exposed to extreme outside temperatures for more than 10 minutes.

3. On or about February 3 to 4, 2019, failed to document and/or communicate client MG's elopement from the secure facility and client MG's fall by doing one or more of the following:

    a) Failed to complete an incident report as required;
    b) Failed to document in the Progress Notes any information pertaining to the elopement or fall;
    c) Failed to report the elopement or fall to oncoming staff at 0700 hours;
    d) Failed to document on the LPN Communication sheet anything pertaining to the elopement or fall; and
    e) Failed to notify appropriate persons of the elopement as required.

4. On or about February 5, 2019, failed to disclose that client MG had eloped from the building and/or provided misleading information when asked if there was a possibility MG could have eloped, the particulars of which are as follows:

    a) Stated that "I don't think there is any possible way that client [MG] could have gone outside and back during the night" of February 3 to 4, 2019;
    b) Provided an account of the events of the evening shift that did not completely and accurately reflect what had occurred during his shift; and
    c) Suggested the possible frostbite could have resulted from the client MG washing his hands with cold water.

5. On or about February 3, 2019, failed to follow proper medication administration practices by doing one or more of the following:

    a) Failed to complete hand hygiene prior to administering medication;
    b) Failed to complete the appropriate rights and checks of medication administration;
    c) Failed to observe client RB consume medication as per policy; and
    d) Failed to administer medications to one client at a time as per policy.

6. On or about February 3, 2019, falsely documented on the Medication Administration Record the time of administration of medications to clients AB and AO as follows:

a) Apo-Gabapentin 300 mg, Melatonin Dual Action 10 mg, and Tar-Phenytoin Oral Suspension 25 mg/ml to client RB as 2031 hours instead of the actual administration time of 1937 and/or 1938 hours; and
b) Mylan-Clozapine 200 mg and Sandoz-Tamsulosin CR 0.4 mg to client AO as 2030 hours instead of the actual administration time of 1937 hours."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits a member to make an admission of unprofessional conduct. An admission under s. 70 of the Act must be acceptable in whole or in part to the Hearing Tribunal.

Bhavneet Verma acknowledged unprofessional conduct to all the allegations as evidenced by his signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and verbally admitted unprofessional conduct to all the Allegations set out in the Revised Statement of Allegations during the hearing.

Legal Counsel for the Complaints Director/Consultant submitted that, where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1:	Revised Statement of Allegations
Exhibit #2:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3:	Joint Submission on Penalty
Exhibit #4:	Module Outline - Professionalism in Nursing (NProf005)
Exhibit #5:	Letter from Mark Wells, Certificates (3), and Declaration

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #2.

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #2, and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Mr. Verma's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submission before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Mr. Verma.

Allegation 1

Bhavneet Verma admitted on or about February 3 to 4, 2019, he failed to appropriately respond to client MG's fall by doing one or more of the following:

a) Failed to adequately assess and/or document an assessment of client MG after a fall as required; and

b) Failed to complete post fall protocol monitoring and/or document on the Post-Fall Clinical Pathway as required.

Mr. Verma was assigned to Unit 3100 at the Facility from 1500 hours on February 3, 2019 to February 4, 2019 at 0700 hours. During this time, he provided care to client MG.

At approximately 1840 hours on February 3, 2019, client MG left the sitting area on Unit 3100, exited Unit 3100, and proceeded to exit the Facility through the east exit doors. Client MG proceeded to walk down the stairs towards the loading dock and remained in the loading area for approximately six minutes. Still photographs from the surveillance cameras on February 3, 2019 showing client MG exiting the Unit and Facility, and standing in the loading area were included in Exhibit #2.

At approximately 1845 hours, Mr. Verma exited the LPN office on Unit 3100 and saw that client MG was no longer in the sitting room. Mr. Verma looked through the other residents' rooms (client MG had a habit of entering co-residents' rooms) as well as client MG's room. Given client MG's history of elopement from the Unit, Mr. Verma exited Unit 3100 and checked the east exit doors.

At approximately 1846 hours, client MG walked back to the stairs and attempted to climb the same. At approximately 1848 hours, Mr. Verma exited the Facility from the east exit doors and walked towards the stairs to the loading dock area. At this time, client MG was attempting to climb the stairs back to the Facility and while near the top of the stairs, client MG fell backwards. Mr. Verma reached out towards the client but was unable to catch client MG before he fell. Still photographs from the surveillance cameras on February 3, 2019 showing client MG climbing the stairs and falling were included in Exhibit #2.

Mr. Verma then assisted client MG to lift him up from the ground. Mr. Verma had called the other LPN on duty, Mr. Jasbir Rai, to assist him. Thus, at approximately 1850 hours, Mr. Rai attended Mr. Verma and client MG and assisted with transferring client MG back into the Facility. Still photographs from the surveillance cameras on February 3, 2019 showing Mr. Verma and Mr. Rai assisting client MG up and into the Facility were included in Exhibit #2.

Mr. Verma, Mr. Rai, and client MG entered back into the Facility at approximately 1851 hours through the east exit doors. The LPNs assisted client MG to a chair just inside the east exit doors. Mr. Verma exited the Facility, obtained client MG's walker and brought it back inside. Mr. Verma then went back into Unit 3100 to obtain client MG's coat and brought the same back to the client sitting just inside the east exit doors. Mr. Rai and Mr. Verma placed the jacket onto client MG and then assisted the client back to Unit 3100. Still photographs from the surveillance cameras on February 3, 2019 showing these events were included in Exhibit #2**.**

At approximately 1856 hours, client MG with Mr. Rai and Mr. Verma entered Unit 3100. Mr. Rai and Mr. Verma guided the client towards the chair he previously occupied in the sitting room. Mr. Rai and Mr. Verma sat client MG in the chair and proceeded to rub the client's hands. Still photographs from the surveillance cameras on February 3, 2019 showing Mr. Rai and Mr. Verma assisting client MG in Unit 3100 were included in Exhibit #2**.**

Balwin's LPN Reportable Incident Reporting Process specifies that in the case of client falls, the client should be treated and assessed according to the AHS Post Fall Clinical Pathway assessment sheet (the "Pathway"). A copy of the LPN Reportable Incident Reporting Process was included in Exhibit #2.

The Pathway is used in conjunction with AHS's Post-Fall Clinical Monitoring Guide. These documents require that the LPN complete a post-fall head-to-toe assessment of the client as well as monitoring of a client's vital signs, pain and behavior. The Pathway document must also be filled out to reflect the clinical decisions of the LPN. Copies of the Post-Fall Clinical Monitoring Guide and the Pathway were included in Exhibit #2**.**

Despite these requirements, at no time after witnessing client MG's fall did Mr. Verma complete or document an assessment of client MG. Mr. Verma further failed to complete and document any post-fall protocol monitoring as required by the AHS guide and Post-Fall Clinical Pathway.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Verma's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 1 did in fact occur.

A fall is a serious event and requires an assessment of the patient's condition and documentation of the fall on the patient's chart, after a fall occurs. Mr. Verma failed to make this assessment of MG's condition after the fall and he did not document this assessment or the fall according to AHS and Post-Fall Clinical Pathway which is the standard procedure of the Facility in which Mr. Verma worked. The assessment of a patient, as well as, the documentation

of the incident is critical to the ongoing care and treatment of the patient. This conduct shows a lack of basic nursing skill, and judgment.

In addition, the Hearing Tribunal finds that Mr. Verma's conduct breached the CLPNA Code of Ethics ("Code of Ethics") and CLPNA's Standards of Practice ("Standards of Practice"), as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. In particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the Act], a code of ethics or standards of practice.

Allegation 2

Bhavneet Verma admitted on or about February 3 to 4, 2019, he failed to adequately assess and/or document an assessment of MG after MG was exposed to extreme outside temperatures for more than 10 minutes.

As above, Mr. Verma was assigned to Unit 3100 at the Facility from 1500 hours on February 3, 2019 to February 4, 2019 at 0700 hours and during this time provided care to client MG.

As outlined above under Allegation 1, on February 3, 2019 at approximately 1840 hours, client MG was able to elope from Unit 3100 and the Facility. Mr. Verma and Mr. Rai assisted client MG back into the Facility at approximately 1851 hours. By this time, client MG had spent approximately 12 minutes outside.

Weather observations from Environment and Climate Change Canada for the monitoring station closest to the Facility measured the temperature at -29 degrees Celsius with a wind chill value of between -37 and -38 degrees Celsius during the time in which client MG was outside. A copy of the Environment and Climate Change Canada Hourly Data Report for February 3, 2019 was included in Exhibit #2.

Despite finding client MG outside in these extreme temperatures, Mr. Verma failed to assess and document an assessment of client MG. Mr. Verma's efforts were limited to asking if the client MG was in pain prior to assisting him off the ground following his fall as described above, putting a coat on client MG and rubbing client MG's hands once they were inside the Facility. There is no documentation of any assessment. A copy of client MG's Progress Notes were included in Exhibit #2.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Verma's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 2 did in fact occur.

MG was exposed for a significant period of time to extreme temperatures, and did require follow-up treatment for the blisters on his hands from the cold. Mr. Verma's failure to assess or document MG's condition after his elopement demonstrates a lack of skill and judgment on Mr. Verma's part. This assessment is vital to the proper care of a patient in this situation. Treatment, if required, and continuity of care could have been compromised. Assessment of a patient's condition after an event of this magnitude is basic nursing skills, as well as, a procedural expectation for a nurse.

In addition, the Hearing Tribunal finds that Mr. Verma's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. In particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the Act], a code of ethics or standards of practice.

Allegation 3

Bhavneet Verma admitted on or about February 3 to 4, 2019, he failed to document and/or communicate client MG's elopement from the secure facility and client MG's fall by doing one or more of the following:

a) Failed to complete an incident report as required;
b) Failed to document in the Progress Notes any information pertaining to the elopement or fall;
c) Failed to report the elopement or fall to oncoming staff at 0700 hours;
d) Failed to document on the LPN Communication sheet anything pertaining to the elopement or fall; and
e) Failed to notify appropriate persons of the elopement as required.

As stated above, Mr. Verma was assigned to Unit 3100 at the Facility from 1500 hours on February 3, 2019 to February 4, 2019 at 0700 hours and during this time provided care to client MG.

Also as outlined above under Allegations 1 and 2, during the evening shift client MG eloped from the Facility, spent approximately 12 minutes in extreme outside temperatures, and suffered a fall while outside.

The Excel Society's policy on Incident Reporting requires that all incidents, which include falls and missing clients, be reported and recorded for quality improvement. The incidents must be immediately reported to the Site Supervisor and/or On-call Supervisor and documented by the

employee who is first on the scene or first becomes aware of the incident. An incident report must be filled out by the end of the employee's shift and submitted to the Site Supervisor. A copy of the Incident Reporting Policy was included in Exhibit #2.

The Excel Society has a further policy on Unusual Incident Reporting. This policy requires all support persons to complete an Unusual Incident Report for all unusual incidents or accidents. This includes serious client/resident situations and/or behaviors of concern, as well as, any other incidents or accidents of a serious or unusual nature. A copy of the Unusual Incident Reporting policy was included in Exhibit #2**.**

The LPN Reportable Incident Reporting Process requires that falls be documented and reported to the next shift. Additionally, there are reporting requirements specific to an eloped resident outlined in the LPN Reportable Incident Reporting Process as well as the Code Yellow Process. The Reportable Incident Process requires that for elopement of a resident, the LPN follows the Code Yellow Procedure. It also requires that the staff member notify the site on-call supervisor by phone and complete a follow-up email to the Resident Care Manager and the Director of Designated Assisted Living. The Reportable Incident Process further indicates that between the hours of 0800 hours and 2300 hours, staff must notify the Supportive Living On-call Manager by contacting the CCA if the resident returns or is located. A copy of the Reportable Incident Process was included in Exhibit #2**.**

The Code Yellow Procedure requires the staff member who suspects a client is missing to immediately alert the Coordinator and Manager. A search is then conducted by the coordinator and available staff. A copy of the Operations Manual section on Code Yellow-Missing Client was included in Exhibit #2**.**

Finally, under the Excel Society's Progress Notes Policy, staff members are required to write progress notes on the completion of a shift and after a special event or critical incident. A copy of the Progress Notes Policy was included in Exhibit #2**.**

Client MG's elopement and fall on February 3, 2019 constitutes an incident that required documentation and reporting under the Excel Society's policies described in the foregoing paragraphs. Mr. Verma was the first employee to become aware of client MG's elopement and fall; he was therefore subject to the reporting and documentation requirements under the Facility policies.

Despite these requirements, Mr. Verma failed to complete an incident report regarding either client MG's elopement or fall. Mr. Verma further failed to document in client MG's progress notes any information regarding the elopement or the fall that occurred during Mr. Verma's evening shift. A copy of client MG's Progress Notes were included in Exhibit #2.

Mr. Verma also failed to notify any member of management, including the Site Supervisor or On-call Supervisor, Coordinator, Manager or Director regarding client MG's elopement as required by the Facility's policies.

Finally, at the end of his shift at 0700 hours on February 4, 2019, Mr. Verma failed to report client MG's elopement or fall to the oncoming staff. Mr. Verma did not provide a verbal report of these incidents or document any information regarding the elopement or fall in the LPN Communication sheet. A copy of the LPN Communication sheet for February 3-4, 2019 was included in Exhibit #2**.**

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Verma's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 3 did in fact occur.

The Hearing Tribunal reviewed and confirmed the lack of charting of the elopement of MG, the failure to communicate the elopement to oncoming staff, and the failure to record the elopement as required by standard operating procedures, as not only failing to perform basic nursing functions, but also what can be considered a hiding of the event from the other nursing staff. This is not only a demonstration of poor nursing skills, and poor judgment, this could have been very serious in the treatment needs and proper follow-up care of MG after such an extreme exposure to the elements. This lack of documentation and communication about MG's elopement by Mr. Verma, is found by the Hearing Tribunal to be dishonest at its core, and therefore, in addition to it showing a lack of skill and judgment, it is also conduct that harms the integrity of the profession which is sufficiently serious to constitute unprofessional conduct.

In addition, the Hearing Tribunal finds that Mr. Verma's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. In particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of this Act [the Act], a code of ethics or standards of practice; and
xii. Conduct that harms the integrity of the regulated profession.

Allegation 4

Bhavneet Verma admitted on or about February 5, 2019, he failed to disclose that client MG had eloped from the building and/or provided misleading information when asked if there was a possibility MG could have eloped, the particulars of which are as follows:

a) Stated that "I don't think there is any possible way that client [MG] could have gone outside and back during the night" of February 3 to 4, 2019;
b) Provided an account of the events of the evening shift that did not completely and accurately reflect what had occurred during his shift; and

c) Suggested the possible frostbite could have resulted from the client MG washing his hands with cold water.

On February 4, 2019, the dayshift Health Care Attendant ("HCA") attended client MG to provide morning care and get him up for breakfast; client MG refused the same complaining of leg pain. At this time, the HCA noticed blisters on most of client MG's fingers and notified the day LPN, Kelly Lepps. Ms. Lepps attended client MG and conducted an assessment. She observed that client MG had warm skin with flushed cheeks, blisters on the right and left finders, and was more confused than his baseline. Ms. Lepps called the Emergency Community Care Urgent Response Team ("ECCURT") and notified client MG's guardian. Client MG's Progress Notes were included in Exhibit #2.

The ECURRT Team assessed client MG and determined that he should be transported to hospital. Client MG was transported to the Royal Alexandra Hospital at 1130 hours on February 4, 2019. Client MG's Progress Notes were included in Exhibit #2.

At 1412 hours on February 4, 2019, Ms. Lepps emailed the other LPNs employed at the Facility to report that EMS suspected client MG had a possible injury to his left thigh and frostbite to his fingers. She recounted the events as outlined in the Progress Notes. A copy of Ms. Lepps' email was included in Exhibit #2**.**

Ms. Lepps' email was forwarded on to the Director of Designated Assisted Living, Becky Elkew, as staff were unsure as to whether client MG could have gone outside by himself. Ms. Elkew forwarded the email to Mr. Verma and the HCA on shift, Mr. Montealegre, and asked them directly whether client MG could have gone outside and back during the night of February 3-4, 2019. These emails were included in Exhibit #2.

On February 5, 2019, Mr. Verma replied to Ms. Elkew's email but failed to disclose that client MG had eloped from the building. Rather, Mr. Verma provided misleading information, stating: "No, I don't think there is any possible way that client could have gone outside and back during the night". Mr. Verma outlined his observations during his shift, recalling that he saw client MG awake and washing his hands with cold water at around 0315 hours on February 4, 2019 and indicated this could have been the cause of the frostbite. In his reply to Ms. Elkew, Mr. Verma made no mention of client MG's elopement or fall. These emails were included in Exhibit #2.

Client MG's guardian communicated his concern to Balwin following the incident and provided photographs of Client MG's fingers taken while at the Royal Alexandra Hospital. Both the Complaint and Exhibit #2 contained photographs of client MG's fingers**.**

The Facility began an internal investigation into the incident and placed Mr. Verma on an administrative leave pending the outcome of the investigation.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Verma's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 4 did in fact occur.

Being a nurse is being in a position of trust. That trust is at the very core of the nursing profession and is the bulwark of its integrity. The Hearing Tribunal finds the dishonesty of Mr. Verma to be harmful to the profession, and this dishonesty could have lead to possible and serious lack of care that MG required for the frostbite on his fingers. The Hearing Tribunal finds this conduct to not only be a lack of skill and judgment, but also conduct that can lead to far reaching and serious consequences. In addition, similar to the finding for Allegation 3, the dishonesty that occurred here harms the integrity of the profession and is sufficiently serious to constitute unprofessional conduct.

In addition, the Hearing Tribunal finds that Mr. Verma's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. In particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of this Act [the Act], a code of ethics or standards of practice;

xii. Conduct that harms the integrity of the regulated profession.

Allegation 5

Bhavneet Verma admitted on or about February 3, 2019, he failed to follow proper medication administration practices by doing one or more of the following:

a) Failed to complete hand hygiene prior to administering medication;
b) Failed to complete the appropriate rights and checks of medication administration;
c) Failed to observe client RB consume medication as per policy; and
d) Failed to administer medications to one client at a time as per policy.

As above, Mr. Verma worked the evening shift on February 3, 2019. During this shift, he administered medications to residents on Unit 3100.

The Facility uses a medication cart equipped with a laptop which has an electronic Medication Administration Record ("MAR"). The Excel Society policy on Medication Administration requires that nursing staff, *inter alia*:

a. Administer medications within one hour (before or after) the specified time of administration;

b. Wash their hands prior to and after medication administration for each client;

c. Administer medication one person at a time and refer to each individual by name when giving medication and verify each client by referring to their photo;

d. Ensure that all 7 Medication Rights (right person, right medication, right time, right dose, right route, right documentation, and right response) are checked before during and after mediation administration (3 checks);

e. Ensure each individual has completely taken the mediation (swallowed etc.); and

f. Initial the correct box on the MAR for each specific medication administration date and time indicating the medication was given.

A copy of the Medication Administration Policy was included in Exhibit #2.

At approximately 1935 hours on February 3, 2019, Mr. Verma began to administer medications to residents from the medication administration cart. Prior to doing so, he reached down and tied his shoelaces and then proceeded with the medication administration without performing hand hygiene.

Mr. Verma failed to follow proper medication administration practices when administering medications to clients RB and AO as follows:

a. At approximately 1937 hours, Mr. Verma provided a bottle of Tar-Phenytoin Oral Suspension 25 mg/ml to client RB without having the electronic MAR open or verifying RB's identity;

b. Mr. Verma did not watch client RB to ensure that the client took the Tar-Phenytoin Oral Suspension provided;

c. Prior to finishing the medication administration for client RB, Mr. Verma stopped client RB's administration and administered Mylan-Clozapine 200 mg and Sandoz-Tamsulosin CR 0.4 mg to client AO;

d. Mr. Verma administered the Mylan-Clozapine and Sandoz-Tamsulosin CR to client AO at 1937 hours without the electronic MAR open or verifying AO's identity;

e. Mr. Verma then returned to administering medication to RB at 1938 hours. At this time he provided Apo-Gabapentin 300 mg and Melatonin Dual Action 10 mg to client RB but left the area prior to observing client RB take the medication; and

f. Mr. Verma failed to check the time of administration for medications administered to both AO and RB as both medications were ordered to be administered at 2100 hours but were administered between 1937 and 1938 hours.

A copy of client RB's MAR and client AO's MAR were included in Exhibit #2**.**

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Verma's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 5 did in fact occur.

In this allegation there are a series of procedural failures that have been demonstrated. From hand washing to not following medication protocols, such as making sure a patient had taken their medications, or giving medications to one patient at a time according to protocol, and not checking right medication to the right patient, also according to protocol. Hand washing and following proper medication administration is a critical and basic nursing skill. Failing to wash one's hands is not only basic nursing skills, it is also common knowledge—failing to wash one's hands leads to the potential spread of pathogens. This is nursing care at a foundational level. Proper medication administration protocol and procedures are critical skills to ensure safe care and treatment of patients. This is also a core nursing skill.

In addition, the Hearing Tribunal finds that Mr. Verma's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. In particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Allegation 6

Bhavneet Verma admitted on or about February 3, 2019, he falsely documented on the Medication Administration Record the time of administration of medications to clients AB and AO as follows:

a) Apo-Gabapentin 300 mg, Melatonin Dual Action 10 mg, and Tar-Phenytoin Oral Suspension 25 mg/ml to client RB as 2031 hours instead of the actual administration time of 1937 and/or 1938 hours; and
b) Mylan-Clozapine 200 mg and Sandoz-Tamsulosin CR 0.4 mg to client AO as 2030 hours instead of the actual administration time of 1937 hours.

As above, Mr. Verma worked the evening shift on February 3, 2019 and during this shift, administered medications to clients RB and AO.

Nursing staff at the Facility administer medication using the electronic MAR and are required to initial the correct box on the MAR for each specific medication administration date and time indicating the medication was given. The Medication Administration Policy was included in Exhibit #2.

Mr. Verma administered client RB's Tar-Phenytoin Oral Suspension 25 mg/ml at 1937 hours and the Apo-Gabapentin 300 mg, Melatonin Dual Action 10 mg at 1938 hours on February 3, 2019. Despite this, Mr. Verma falsely documented as having administered these medications to client RB at 2031 hours. Client RB's MAR was included in Exhibit #2**.**

Similarly, while Mr. Verma administered Mylan-Clozapine 200 mg and Sandoz-Tamsulosin CR 0.4 mg to client AO at 1937 hours on February 3, 2019, Mr. Verma falsely documented on client AO's MAR as having administered these medications to client AO at 2030 hours. Client AO's MAR was included in Exhibit #2.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Verma's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 6 did in fact occur.

It is important that medication administration is done on time and correctly, as this can have a serious affect on any number of conditions for a patient from pain control to regulating any number of functions in the body. In this situation the medications were not given in a timely manner; Mr. Verma falsified the times that these medications were given. As the Hearing Tribunal has stated earlier in this decision, honesty is at the very core of the nursing profession. The Hearing Tribunal appreciates and understands that a Facility such as the one Mr. Verma works in can be very busy and somewhat hectic from time to time, but it is a Nurse's responsibility to manage those hectic times with skill and good judgment. The Hearing Tribunal finds that skill, good judgement, and honesty were missing in the above situation, and has found the conduct unprofessional.

In addition, the Hearing Tribunal finds that Mr. Verma's conduct breached the Code of Ethics and the Standards of Practice, as outlined below in this decision, and such breaches are sufficiently serious to constitute unprofessional conduct.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act. In particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of this Act [the Act], a code of ethics or standards of practice; and
xii. Conduct that harms the integrity of the regulated profession.

Breaches of the Code of Ethics

Mr. Verma's conduct breached the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

> Principle 1: Responsibility to the Public - LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically provides that LPNs:

- 1.1 Maintain standards of practice, professional competence and conduct; and

- 1.5 Provide care directed to the health and well-being of the person, family, and community.

Principle 2: Responsibility to Clients – LPNs provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

- 2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities;

- 2.8 Use evidence and judgement to guide nursing decisions; and

- 2.9 Identify and minimize risks to clients.

Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:

- 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession; and

- 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.

Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 specifically provides that LPNs:

- 5.1 Demonstrate honesty, integrity and trustworthiness in all interactions; and

- 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.

Breaches of the Standards of Practice

Mr. Verma's conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which state as follows:

Standard 1: Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

- 1.1. Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies;

- 1.2. Engage in ongoing self-assessment of their professional practice and competence, and seek opportunities for continuous learning;

- 1.4. Recognize their own practice limitations and consult as necessary;

- 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised;

- 1.7. Incorporate established client safety principles and quality assurance/improvement activities into LPN practice;

- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses; and

- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

Standard 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice. Standard 2 specifically provides that LPNs:

- 2.1. Possess current knowledge to support critical thinking and professional judgement;

- 2.2. Apply knowledge from nursing theory and science, other disciplines, evidence to inform decision making and LPN practice;

- 2.7. Demonstrate understanding of their role and its interrelation with clients and other health care colleagues; and

- 2.11. Use critical inquiry to assess, plan and evaluate the implications of interventions that impact client outcomes.

Standard 3: Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

- 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice;

- 3.4 Promote a culture of safety by using established occupational health and safety practices, infection control, and other safety measures to protect clients, self and colleagues from illness and injury;

- 3.5. Provide relevant and timely information to clients and co-workers; and

- 3.6 Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

Standard 4: Ethical Practice – LPNs uphold, promote and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

- 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs;

- 4.4. Develop ethical decision-making capacity and take responsible action toward resolution;

- 4.7. Communicate in a respectful, timely, open and honest manner; and

- 4.10. Practice with honesty and integrity to maintain the values and reputation of the profession.

(9) Joint Submission on Penalty

The Complaints Consultant and Mr. Verma made a joint submission with respect to penalty, which was entered as Exhibit #3. The parties jointly submitted the following proposal to the Hearing Tribunal for consideration:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. The interim suspension imposed by letter dated March 7, 2019 is lifted as of July 23, 2019.

3. Mr. Verma shall pay costs of the hearing in the amount of $2,000 to be paid in equal monthly installments over a period of **36 months** from service of the Decision.

4. Mr. Verma shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Bhavneet Verma shall provide a signed written declaration to the

Complaints Consultant, within **30 days** of service of the Decision, attesting he has reviewed CLPNA's documents:

a. Code of Ethics for Licensed Practical Nurses in Canada;
b. Standards of Practice for Licensed Practical Nurses in Canada;
c. CLPNA Practice Policy: Professional Responsibility & Accountability;
d. CLPNA Practice Policy: Documentation;
e. CLPNA Competency Profile B1: Assessment;
f. CLPNA Competency Profile C4: Client Safety;
g. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;
h. CLPNA Competency Profile E2: Clinical Judgment and Decision Making;
i. CLPNA Competency Profile U2: Medication Preparation and Administration; and
j. CLPNA Competency Profile W4: Professional Ethics.

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.

5. Mr. Verma shall complete shall complete, at his own cost, the following course: **Professionalism in Nursing** located on website www.jcollinsconsulting.com. Mr. Verma shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **90 days** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Mr. Verma shall complete, at his own cost, the following course: **Reducing Medication Errors: A focus on the Medication Pass** located on website www.pedagogy.com. Mr. Verma shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

7. Mr. Verma shall complete, at his own cost, the following course: **Documentation and Reporting** located on website www.coursepark.com. Mr. Verma shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

8. Mr. Verma shall complete the following course: **Health Assessment Self-Study Course** available on CLPNA website at www.clpna.com. Mr. Verma shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

9. Mr. Verma shall provide the CLPNA with his contact information, including his home mailing address, home and cellular telephone numbers, current e-mail address and his current employment information. Mr. Verma will keep his contact information current with the CLPNA on an ongoing basis.

10. Should Mr. Verma be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

11. Should Mr. Verma fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Consultant may do any or all of the following:

    (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

    (b) Treat Mr. Verma's non-compliance as information for a complaint under s. 56 of the Act; or

    (c) In the case of non-payment of the costs described in paragraph 3 above, suspend Mr. Verma's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

Legal Counsel for the Complaints Director submitted the primary purpose of orders from the Hearing Tribunal is to protect the public. The Hearing Tribunal is aware that s. 82 of the Act sets out the available orders that the Hearing Tribunal is able to make if unprofessional conduct is found.

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, that the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should defer to a joint submission unless the proposed

sanction is unfit, unreasonable or contrary to public interest. Joint submissions make for a better process and engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions, and may significantly impair the ability of the Complaints Director/Consultant to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns.

The Hearing Tribunal therefore carefully considered the Partial Joint Submission on Penalty proposed by Mr. Verma and the Complaints Consultant.

(10) Decision on Penalty and Conclusions of the Hearing Tribunal

The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable and proportionate, taking into account the facts of this case.

The order imposed by the Hearing Tribunal must protect the public from the type of conduct that Mr. Verma has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in the decision of *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the investigated member
- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

The nature and gravity of the proven allegations

The proven Allegations against Mr. Verma are serious and had the potential of producing serious outcomes. The failure to document and assess a patient's condition after an event such as an elopement into frigid temperatures has a direct consequence for a patient's care and treatment. In this case, the elopement of client MG, there was evidence of frostbite on his finger tips that was not tended to immediately because of Mr. Verma's failure to document the

elopement and assess MG's condition after retrieving him from the outdoors. In addition, in this instance, Mr. Verma not only failed to document the incident, he also tried to hide the fact that the elopement occurred. Honesty in the practice of nursing is a core value, and the Hearing Tribunal considers this to be a serious misconduct, in that it not only brings disrepute to the profession, but it is also a core value in the profession and is a vital part of the trust the profession has with the public.

With respect to Mr. Verma's failure in properly following Medication Administration procedures, this is also a serious misconduct that can lead to improper care of a patient's ailments that are dependent on proper dosage and timing. This can cause harm to a patient and even unnecessary discomfort. This is particularly concerning when the patients are elderly and vulnerable, as were the patients in the Facility Mr. Verma worked in. Poor medication documentation and errors can lead to problems in a patient's continuity of care.

Therefore, the Hearing Tribunal considers the conduct that was found to have occurred here to be very serious in the scale of conduct.

The age and experience of the investigated member

Mr. Verma was a recent LPN graduate: he graduated on May 10, 2018. He had been practicing mere months when his misconduct occurred. However, the Hearing Tribunal sees this as a serious failing because all of Mr. Verma's misconduct was in basic nursing skills and procedures. He should have known better and should have performed these duties without errors.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions

The Hearing Tribunal received no evidence that Mr. Verma has had any other complaints against him.

The age and mental condition of the victim, if any

The clients in Mr. Verma's Facility were elderly and potentially vulnerable, and dependent on their nurse's proper care and adherence to all procedures affecting them.

The number of times the offending conduct was proven to have occurred

There were multiple occurrences of misconduct over one night. The Hearing Tribunal understands that sometimes a shift can be rather hectic, with a lot of activities; however, even for a relatively new nurse, the ability to carry out basic duties and report and communicate significant events such as elopement are basic nursing skills and should be well established in a nurse's abilities by the time they graduate.

The role of the investigated member in acknowledging what occurred

The Hearing Tribunal commends Mr. Verma on his final acknowledgment of what occurred. In addition, the Hearing Tribunal was pleased to see that Mr. Verma worked with the CLPNA and his legal counsel to come to an Agreed Statement of Facts and a Joint Submission on Penalty.

The Hearing Tribunal finds that Mr. Verma's commitment to use this opportunity to hone his skills are impressive, as well. He has completed all the courses, but one, of studies that were given to him in the Joint Submission on Penalty, as submitted by Mr. Mark Wells, and evidence of his completions were included in Exhibit # 5.

Mr. Verma, according to Mr. Wells, is presently starting his studies on the last course mandated under the Hearing Tribunal's penalties called, "Professionalism in Nursing (NProf995)".

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made

Mr. Verma's employment with the Facility was terminated at the time the misconduct happened.

The impact of the incident(s) on the victim

The Hearing Tribunal was shown evidence of blisters on the hands of MG (an indication of frostbite) after his elopement from the Facility and, because Mr. Verma did not report this incident, there was a delay in MG getting treatment for his frostbite. However, the Hearing Tribunal was not given any evidence that the clients under Mr. Verma's care suffered any other impacts from Mr. Verma's misconduct.

The presence or absence of any mitigating circumstances

Mr. Wells opined to the Hearing Tribunal regarding Mr. Verma's situation, telling the Hearing Tribunal that Mr. Verma was applying his skills as a new LPN under very difficult and unusual conditions. In addition, Mr. Wells indicated that Mr. Verma was alone during this time.

The Hearing Tribunal understands the stress and strain that can happen when a recent graduate finds themselves alone and in charge; however, the situations that Mr. Verma faced required basic nursing skills. The Hearing Tribunal believes that the "newness" of the nurse's graduation is not a mitigating factor here, as all of the misconduct is within the basic and expected nursing skills of recently graduated nurse.

It is important to the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

The Hearing Tribunal is authorized under s. 82(1) of the Act to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. The interim suspension imposed by letter dated March 7, 2019 is lifted as of July 23, 2019.

3. Mr. Verma shall pay costs of the hearing in the amount of $2,000 to be paid in equal monthly installments over a period of **36 months** from service of the Decision.

4. Mr. Verma shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Bhavneet Verma shall provide a signed written declaration to the Complaints Consultant, within **30 days** of service of the Decision, attesting he has reviewed CLPNA's documents:

    a. Code of Ethics for Licensed Practical Nurses in Canada;

    b. Standards of Practice for Licensed Practical Nurses in Canada;

    c. CLPNA Practice Policy: Professional Responsibility & Accountability;

    d. CLPNA Practice Policy: Documentation;

    e. CLPNA Competency Profile B1: Assessment;

    f. CLPNA Competency Profile C4: Client Safety;

    g. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

    h. CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

    i. CLPNA Competency Profile U2: Medication Preparation and Administration; and

    j. CLPNA Competency Profile W4: Professional Ethics.

    If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.

5. Mr. Verma shall complete shall complete, at his own cost, the following course: **Professionalism in Nursing** located on website www.jcollinsconsulting.com. Mr. Verma

shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **90 days** of service of the Decision.

If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Mr. Verma shall complete, at his own cost, the following course: **Reducing Medication Errors: A focus on the Medication Pass** located on website www.pedagogy.com. Mr. Verma shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

7. Mr. Verma shall complete, at his own cost, the following course: **Documentation and Reporting** located on website www.coursepark.com. Mr. Verma shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

8. Mr. Verma shall complete the following course: **Health Assessment Self-Study Course** available on CLPNA website at www.clpna.com. Mr. Verma shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

9. Mr. Verma shall provide the CLPNA with his contact information, including his home mailing address, home and cellular telephone numbers, current e-mail address and his current employment information. Mr. Verma will keep his contact information current with the CLPNA on an ongoing basis.

10. Should Mr. Verma be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

11. Should Mr. Verma fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Consultant may do any or all of the following:

(d) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

(e) Treat Mr. Verma's non-compliance as information for a complaint under s. 56 of the Act; or

(f) In the case of non-payment of the costs described in paragraph 3 above, suspend Mr. Verma's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 10 above, and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, sections 87(1)(a),(b) and 87(2) of the *Health Professions Act*, the investigated member has the right to appeal:

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.
>
> **(2)** A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 19th DAY OF AUGUST 2019 IN THE VILLAGE OF RYLEY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Nancy Brook, Public Member
Chair, Hearing Tribunal